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No. 80-1594

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1980

UNITED STATES of AMERICA, PETITIONER

-VS-

ERIKA, INC.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

BRIEF OF AMICUS CURIAE IN SUPPORT OF RESPONDENT

AMERICAN ACADEMY OF FAMILY PHYSICIANS

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QUESTION PRESENTED

DOES THE COURT OF CLAIMS HAVE JURISDICTION UNDER 28 U.S.C. (& Supp. III) § 1941 TO REVIEW DECISIONS MADE BY A PRIVATE INSURANCE CARRIER CHARGED WITH THE ADMINISTRATION FOR PART B OF THE MEDICARE ACT, 42 U.S.C. (& Supp. III) § 1395, *ET SEQ*?

TABLE OF CONTENTS

	Page
I. TABLE OF AUTHORITIES	iii
II. INTEREST OF AMICUS CURIAE	1
III. OVERVIEW OF MEDICARE PROGRAM	3
IV. ARGUMENT	7
(A). NEITHER THE MEDICARE ACT NOR PROVISIONS OF THE SOCIAL SECURITY ACT INCORPORATED INTO THE MEDICARE ACT EVIDENCE CLEAR AND CONVINCING LEGISLATIVE INTENT TO BAR JUDICIAL REVIEW OF ALL CARRIER DETERMINATIONS CONCERNING MEDICARE PART B BENEFITS	7
(B). IF CLEAR AND CONVINCING EVIDENCE TO FORECLOSE ALL REVIEW FOR ALL PART B CLAIMS IS ESTABLISHED, THE MEDICARE STATUTE (42 U.S.C. § 1395ff) WOULD BE AN UNCONSTITUTIONAL DENIAL OF DUE PROCESS	22
V. SUMMARY OF ARGUMENT	31
VI. CONCLUSION	33

I. TABLE OF AUTHORITIES

Cases:	Page
Abbott Laboratories v *Gardner*, 387 U.S. 136 (1967)	7, 9
American Nursing Centers, Inc., et al v *Weinberger*, 387 F Supp 1116 (S.D. Ill. 1975)	10
Aquavella v *Harvey*, 615 F 2d 12 (2d Cir., 1979)	27
Aquavella v *Richardson*, 437 F 2d 397 (2d Cir., 1971)	10
Armstrong v *Manzo*, 380 U.S. 545 (1965)	26
Batterton v *Francis*, 432 U.S. 416 (1977)	17
Califano v *Sanders*, 430 U.S. 99 (1977)	7
Chelsea Community Hospital v *Michigan Blue Cross Association*, 630 F 2d 1131 (6th Cir., 1980)	11
Citizens to Preserve Overton Park, Inc. v *Volpe*, 401 U.S. 402 (1971)	7
Crowell v *Benson*, 285 U.S. 22 (1932)	22
Davis v *Richardson*, 460 F 2d 772 (3d Cir., 1972)	10
Dr. John T. MacDonald Foundation, Inc., v *Califano*, 571 F 2d 328 (5th Cir. 1978) *cert den* 439 U.S. 893 (1978)	11
Dunlap v *Bachowski*, 421 U.S. 560 (1975)	7
Ex Parte McCardle, 7 Wall. 506, 19 L. Ed. 264 (U.S., 1869)	22
Flemming v *Nestor*, 363 U.S. 603 (1960)	27
Friedman v *Berger*, 409 F Supp 1225 (S.D. N.Y., 1976)	3
Friedman v *Berger*, 547 F 2d 722 *cert den* 430 U.S. 984 (1977)	3
Johnson v *Robison*, 415 U.S. 361 (1974)	23, 24, 25, 30
Joint Anti-Fascist Committee v *McGrath*, 341 U.S. 123 (1951)	30
Kuenstler v *Occidental Life Insurance Co.*, 292 F Supp 532 (C.D. Cal., 1968)	6

INDEX TO AUTHORITIES—(Cont'd)

Cases:	Page
Maddox v *Richardson*, 464 F 2d 617 (6th Cir., 1972)	10
Mathews v *Eldridge*, 424 U.S. 319 (1976)	26, 27
McClure v *Harris*, 503 F Supp 409 (N.D. Cal., 1980)	14, 28, 29
Michigan Academy of Family Physicians, et al v *Blue Cross Blue Shield of Michigan, et al*, 502 F Supp 751 (E.D. Mich, 1980)	28
Richardson v *Belcher*, 404 U.S. 78 (1971)	27
Richardson v *Perales*, 402 U.S. 389 (1971)	27
Rothman v *Hospital Service of Southern California*, 510 F 2d 956 (9th Cir., 1975)	10
Rusk v *Court*, 396 U.S. 367 (1967)	7
Schweiker v *Gray Panthers*, U.S. , 101 S. Ct. 2633, 69 L. Ed. 2d 460 (1981)	3, 17
South Boston General Hospital v *Weinberger*, 397 F Supp 360 (W.D. Vir., 1975)	10
South Windsor Convalescent Home, Inc. v *Mathews*, 541 F 2d 910 (2d Cir., 1976)	11
St. Joseph Stock Yards Co. v *United States*, 298 U.S. 38 (1936)	22
St. Jude Manor Nursing Home, Inc. v *Richardson*, No. 72-681 (M.D. Flor., filed July 27, 1974), CCH, Medicare and Medicaid Guide New Developments, ¶27,226	28
St. Louis University v *Blue Cross Hospital Service*, 537 F 2d 283 (8th Cir. 1976) *cert den* 429 U.S. 977 (1976)	11
Szekely v *Florida Medical Association*, 517 F 2d 345 (5th Cir. 1975) *cert den* 425 U.S. 980 (1976)	26
Trinity Memorial Hospital of Cudahy, Inc. v *Associated Hospital Service, Inc.*, 570 F 2d 660 (7th Cir., 1977)	11

INDEX TO AUTHORITIES—(Cont'd)

Cases: Page

Udall v *Tallman*, 380 U.S. 1 (1965) 17

United States v *Klein*, 13 Wall. 128 (U.S. 1872) 22

United States v *Thirty Seven Photographs*, 402 U.S. 363 (1971) 30

Weinberger v *Salfi*, 422 U.S. 749 (1975) 11, 20, 21, 24, 25, 31, 32

Whitecliff, Inc. v *U.S.*, 536 F 2d 347 (Ct. Cl., 1976) *cert den* 320 U.S. 969 (1977) 11

Constitutions, Statutes and Regulations:

United States Constitution, Fifth Amendment 26, 32

United States Constitution, Fourteenth Amendment 26, 27

Social Security Act, 42 U.S.C. 301 et seq.

Title II, 42 U.S.C. 401 et seq:

42 U.S.C. 405(g) 18, 19, 20

42 U.S.C. 405(h) 11, 18, 19, 20, 21, 24, 31, 32

Title XVIII, 42 U.S.C. 1395 et seq:

42 U.S.C. 1395a 28

42 U.S.C. 1395b(3)(B)(ii) 26

42 U.S.C. 1395c-1395i 3

42 U.S.C. 1395ff 8, 9, 10, 13, 19, 31

42 U.S.C. 1395ff(b)(1)(A) 9

42 U.S.C. 1395ff(b)(1)(B) 4, 9, 13

42 U.S.C. 1395ff(b)(1)(C) 9

42 U.S.C. 1395i-1395w 3

42 U.S.C. 1395ii 18, 19, 20, 21, 31

42 U.S.C. 1395l 4

42 U.S.C. 1395oo 10, 19

INDEX TO AUTHORITIES—(Cont'd)

Constitutions, Statutes and Regulations:—(Cont'd)	Page
42 U.S.C. 1395t	4
42 U.S.C. 1395u	4, 16
42 U.S.C. 1395u(b)(3)	14
42 U.S.C. 1395u(b)(3)(C)	4, 16
42 U.S.C. 1395u(b)(3)(E)	17
42 U.S.C. 1395u(f)(3)	28
42 U.S.C. 1395y(a)(1)	17
42 U.S.C. 1396 et seq.	3
28 U.S.C. 1331	24, 32
28 U.S.C. 1491	24
42 C.F.R.:	
Section 405.801	13, 26
Section 405.802-405.872	14
Section 405.807	14
Section 405.820	14
Section 405.823	14
Section 405.824	14
Section 405.830(b)	14
Section 405.860	14

INDEX TO AUTHORITIES—(Cont'd)

Miscellaneous:	Page
S. Rep. No. 404, 89th Cong., 1st Sess. (1965)	12
118 Cong. Rec. 33992, 1972.....	12
H.R. Conf. Rep. No. 92-1605, 92nd Cong. 2nd Sess. (1972)	12
Impact of Fiscal Year 1982 Budget Cuts on the Elderly: Hearing before Select Committee on Aging, House of Representatives, 97th Cong., 1st Sess., April 6, 1981, p 30.....	3
Medicare After 15 Years: Has It Become a Broken Promise to the Edlerly? Report by Select Committee on Aging, House of Representatives, 96th Cong., 2nd Sess., November 17, 1980, p 12.....	5
Carriers Manual — Health Care Financing Administration §12016.....	15
§12016B	17
§12020.....	17
Bator, P., et al, *The Federal Courts and the Federal System, Note on Power of Congress to Limit the Jurisdiction of Federal Courts*, 313-375, (2 ed., 1973)	22
Davis, K., *Administrative Law in the Seventies*, § 2809 (1976)	22
Jaffe, *Judicial Control of Administrative Action*, 376-394 (1965).....	22
Ferry, *Physicians Charges Under Medicare: Assignment Rates and Beneficiary Liability*, Health Care Financing Review, Winter 1980.....	55

II. INTEREST OF AMICUS CURIAE

American Academy of Family Physicians (hereinafter Amicus Curiae) is a non-profit professional association consisting of approximately 40,000 family physicians. Amicus Curiae members are physicians educated and trained to develop and exercise, through their practice, an approach and skills which qualify members to provide continuing, comprehensive health care to an entire family, regardless of sex, age, or medical ailment. Amicus Curiae is keenly interested in the delivery of health care, including the various effects that the administration of the Medicare Program may have upon the delivery of health care to the family. Amicus Curiae's general goal is to foster the delivery of primary health, and to this end, Amicus Curiae encourages individuals entering the medical field to specialize in primary care and engages in other projects toward fostering quality primary care.

Amicus Curiae believes that the decision currently before this Court is exceedingly important to the efficient and fair delivery of health care in this country. At issue is the availability of a competent and fair forum to bring grievances concerning the manner by which a major social program—the Medicare Act—is administered. It is Amicus Curiae's position that to reverse the Court of Claims in this case by accepting the arguments made by petitioner would have ramifications outside the limited question concerning jurisdiction of the Court of Claims. Petitioner's argument, if accepted by this Court, would foreclose jurisdiction not only as exercised by the Court of Claims, but other federal courts as well.

While the constituent members of Amicus Curiae are each generally concerned and involved with the Medicare Program, they have no vested or monetary interest in the exact outcome of this case. As a result, Amicus Curiae believes that it is particularly well suited to present a balanced, fair view of the jurisdictional question before this Court. If an objective appraisal of the pertinent statutes is

to be forthcoming and if a balance between competing interests is to be struck, Amicus Curiae believes it can assist this Court in reaching a resolution which will be in the best interests of this country's citizenry and their health. Amicus Curiae hopes to provide this Court with an overview of the issues raised and the way in which this Court's resolution will impact upon the delivery of health care.

III. OVERVIEW OF MEDICARE PROGRAM

The Medicare Program (Title XVIII of the Social Security Act, 42 U.S.C. §1395 *et seq*) is a statutory labyrinth[1] which assures federal payment for a portion of certain medical expenses incurred by persons 65 years of age, or other persons entitled to Social Security benefits.[2] The Secretary of Health, Education and Welfare[3] (hereinafter "Secretary") is given the executive responsibility for administering the Program. Although explained more fully, *infra*, the Secretary is empowered to delegate and has delegated the administration of the Program to private insurance entities.

The Medicare Program consists of two subprograms. Part A of the Program, 42 U.S.C. § 1395c-1395i[4] is a hospital insurance program, whereas, Part B, § 1395i-1395w, is a voluntary, supplemental insurance

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[1] It would seem appropriate to issue a caveat to any court which is about to entertain arguments concerning the interpretation of the Medicare or Medicaid Acts (Titles XVIII and XIX of the Social Security Act, 42 U.S.C. § 1395 *et seq* and § 1396 *et seq*). The warning is perhaps best issued by repeating what jurists have already said about the language these statutes employ. Judge Friendly noted that the Act was "almost unintelligible to the uninitiated", *Friedman* v *Berger*, 547 F 2d 722, 727 n. 7 (2nd Cir 1976) *cert den* 430 U.S. 984 (1977). The District Court in *Friedman* v *Berger*, 409 F Supp 1225 (S.D. N.Y. 1976), described the Act as "an aggravated assault on the English language", and Justice Powell indicated that the Act was "among the most intricate ever drafted by Congress" and had a "byzantine construction." *Schweiker* v *Gray Panthers*, U.S. ; 101 S.Ct. 2633; 69 L. Ed. 2d 460 (1981).

[2] The size of the Program is truly staggering. Recent figures submitted to Congress indicate that 29,331,000,000 Federal dollars were spent on the Medicare Program in 1980. *Impact of Fiscal Year 1982 Budget Cuts on the Elderly: Hearing before the Select Committee on Aging, House of Representatives*, 97th Cong., 1st Sess., April 6, 1981, p 30.

[3] In keeping with the decision rendered by the Court of Claims, reference will be made to the Department of Health, Education and Welfare rather than the Department's new name, Department of Health and Human Services.

[4] All Section references hereafter will be to 42 U.S.C. unless otherwise indicated.

program covering the costs of other medical care. Since the current case arises under Part B, this Court can focus its attention to this subpart. However, the distinction between the subprograms is discussed, *infra*.

Under Part B, Medicare pays supplemental providers, such as individual physicians, or x-ray or diagnostic laboratories, on a "reasonable charge" basis.[5] Those otherwise entitled to Social Security benefits have a deduction taken from their benefits to help cover the cost of the Part B Program. The money so deducted is channeled into the Supplemental Medical Insurance Trust Fund, § 1395t. The monies contained in the Fund are then used to pay Part B benefits and help cover the cost of administering the Program. The Secretary is authorized to enter into contracts with private entities, or "carriers," for the administration of Part B. Said carriers become responsible for (1) making determinations as to rates and payments; (2) receiving, disbursing and accounting for funds; and (3) conducting audits to assure proper payment, § 1395u.

A beneficiary is entitled to a hearing by the Secretary when a challenge to the beneficiary's eligibility to enroll in the Program is made [§ 1395ff(b)(1)(B)]. The Secretary is further empowered to enter into contracts with carriers and the contract is to provide for a "fair hearing by the carrier" if the amount in controversy is $100.00 or more and a challenge of the following types are made: (1) payment for services furnished are denied; (2) payment is not made with reasonable promptness; or (3) payment for a given service is in controversy. [§ 1395u(b)(3)(C)]. However, there is no provision in the Medicare Act which either expressly grants or expressly denies review to a beneficiary or provider for

[5] Part B reimbursement consists of 80% of the "reasonable charge" and "reasonable charge" is the lowest of the actual charge, customary charge or prevailing charge. Consequently, Part B reimbursement is always less than what the provider's actual fee is for a particular service. § 13951.

other types of claims or challenges. From this absence of any explicit statutory provision, the current dispute surrounding statutory construction arises.

It is also beneficial that this Court appreciate the normal practices surrounding disbursement of funds under Medicare. The Medicare Act—Part B—provides two methods for the disbursement of funds. Under the first method, the eligible recipient of funds obtains treatment from a provider, pays the provider directly, and submits a request for payment to the carrier.

Under the second method, patients assign their claims for Medicare benefits to the provider who performed the particular services. The provider then submits all assigned claims to the carrier. It is important for the Court to appreciate the prevalence of the assignment method and the effect this has upon the Program.[6]

The Petitioner paints an unrealistic portrait of the Part B Program to the extent that Part B is characterized by the submission of the multitude of small claims. The reality of the Program is that providers have accepted the majority of claims and are requesting payment from the carrier in relatively large amounts equalling the requests made by Part A providers.

The number of assigned claims is important to appreciate, since it groups claims in a way not necessarily predictable from a perusal of the Act. A provider requesting payment for a large number of claims covering a wide range of services has a wider exposure on how the Program is

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[6] In 1966 two out of three Medicare claims were assigned. The rate of assignment has been dwindling, but is still over 50%. *Medicare after 15 Years: Has It Become a Broken Promise to the Elderly?:* Report by Select Committee on Aging, U.S. House of Representatives, 96th Cong., 2nd Sess., November 17, 1980, p 12. See also Ferry, *Physicians Changes Under Medicare: Assignment Rates and Beneficiary Liability*, Health Care Financing Review, Winter 1980.

generally administered and is more likely to be cognizant of when the Program is being administered unreasonably or illegally.[7]

[7] One indication of this fact is that the cases which have arisen under Part B are generally provider cases, as opposed to beneficiary cases. Despite petitioner's contention that allowing Part B claims a federal judicial forum would inundate the federal courts, petitioner's Brief cites only one Part B case which has been brought by a Medicare beneficiary [*Kuenstler* v *Occidental Life Insurance Co.*, 292 F Supp 532, (C.D. Cal. 1968)]. The simple fact is that it would usually be economically unsound for beneficiaries to pursue a claim concerning a given medical service in Federal Court, since the claim would in most cases, be less than the cost of litigation.

IV. ARGUMENT

NEITHER THE MEDICARE ACT NOR PROVISIONS OF THE SOCIAL SECURITY ACT INCORPORATED INTO THE MEDICARE ACT EVIDENCE CLEAR AND CONVINCING LEGISLATIVE INTENT TO BAR JUDICIAL REVIEW OF ALL CARRIER DETERMINATIONS CONCERNING MEDICARE PART B BENEFITS.

An appropriate starting point in the case at bar is to recognize which party bears the burden of demonstrating legislative intent as it relates to the disputed statutes. In reviewing the Brief submitted by petitioner, one is tempted to conclude that it is Respondent's burden to convince this Court that the pertinent provisions of the Medicare Act explicitly grant federal court jurisdiction to Respondent. Petitioner would seemingly ignore the general rule that any interpretation of a statute dealing with review of administrative decisions that fails to provide for administrative *and* judicial review is suspect unless clear and convincing evidence of a congressional intent to foreclose such review is present. *Abbott Laboratories* v *Gardner*, 387 U.S. 136 (1967); *Rusk* v *Court*, 396 U.S. 367 (1967); *Citizens to Preserve Overton Park, Inc.* v *Volpe*, 401 U.S. 402 (1971); *Dunlap* v *Bachowski*, 421 U.S. 560 (1975); *Califano* v *Sanders*, 430 U.S. 99 (1977).

Petitioner recognizes the presumption in favor of judicial review but argues that the presumption is "reversed" when the pertinent statutes and history are reviewed (Pet. Br., p 37). Obviously, the presumption is not "reversed"; the question becomes whether the presumption is overcome by a clear and convincing showing of intent to foreclose judicial review. It is petitioner's burden to overcome the presumption by persuading this Court that the Court of Claims' decision was erroneous and that the pertinent statutory provisions show an affirmative intent to deprive Part B providers, or beneficiaries, of a judicial forum.

Petitioner's attempt at showing legislative intent by clear and convincing evidence relies upon an analysis of the Medicare Act itself and certain passages from Congressional reports. It is the position of Amicus Curiae that a review of the Act and its history falls far short of showing by clear and convincing means that Congress intended to foreclose review of all Part B claims.

The only section of the Medicare Act which deals directly with review rights under Part B is § 1395ff.[8] A review of that statute, as set out below, indicates that a distinction is drawn between review under Part A and under Part B.

Pursuant to § 1395ff(b), an individual is entitled to a hearing by the Secretary (and judicial review thereafter) as to

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[8] This section currently provides in relevant part:

> (a) The determination of whether an individual is entitled to benefits under part A or part B of this subchapter, and the determination of the amount of benefits under part A of this subchapter, shall be made by the Secretary in accordance with regulations prescribed by him.
>
> (b) (1) Any individual dissatisfied with any determination under subsection (a) of this section as to—
>
> (A) whether he meets the conditions of section 426 or 426a of this title, or
>
> (B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of of this subchapter, or section 1395i-2 of this title or section 1819, or
>
> (C) the amount of benefits under Part A of this subchapter (including a determination where such amount is determined to be zero)
>
> shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.
>
> (2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

determinations concerning: (1) whether the beneficiary is eligible to participate under Part A [§ 1395ff(b)(1)(A)]; (2) whether there is eligiblility to participate in Part B [§ 1395ff(b)(1)(B)]; and (3) the "amount of benefits" payable under Part A [§ 1395ff(b)(1)(C)].

Petitioner argues that this absence of any mention of review for a Part B benefit determination "affirmatively shows that Congress deliberately withheld judicial review of reimbursement claims under Part B." (Pet. Br., p. 23). The language of the staute shows only that Congress did not "affirmatively" say anything about Part B review other than that there was a right to review participation (eligibility) in Part B. Clearly, no more can be said of § 1395ff than it is silent as to review of Part B claims other than Program participation. To specifically *afford* review to certain individuals under one circumstance is hardly clear and convincing evidence that there is an intent to *foreclose* review to individuals in another set of circumstances. This Court faced a similar argument concerning congressional silence in *Abbott Laboratories, supra,* at 141.

> The Government relies on no explicit statutory authority for its argument that pre-enforcement review is unavailable but insists instead that because the statute includes a specific procedure for such review of certain enumerated kinds of regulations, not encompassing those of the kind involved here, other types were necessarily meant to be excluded from any pre-enforcement review. The issue, however, is not so readily resolved; we must go further and inquire whether in the context of the entire legislative scheme the existence of that circumscribed remedy evinces a congressional purpose to bar agency action not within its purview from judicial review. As a leading authority in this field has noted, "The mere fact that some acts are made reviewable should not suffice to support an implication of exclusion as to others. The right to

review is too important to be excluded on such slender indeterminate evidence of legislative intent." (footnote deleted)

Moreover, the fact that § 1395ff distinguishes between Part A and Part B in delineating review rights cannot be used as an indication that there was an intent to foreclose review under Part B. As petitioner notes, § 1395ff was rewritten in 1972 and § 1395oo was added. Petitioner argues that an intent to foreclose review can be gleaned from the fact that Congress, in amending the Medicare Act in 1972, specifically expanded the review rights under Part A, but left Part B unchanged. The history of review afforded under Part A does not lead to the conclusion that in expanding review under Part A, Congress intended to foreclose review under Part B.

One can start with the fact that prior to the 1972 amendments, the review afforded to providers in Part A and Part B services was quite similar, i.e., § 1395ff was silent as to whether challenges made by a provider to the amount of benefits for a given service could be reviewed under either subpart. Despite this Congressional silence, the federal courts held that judicial review was afforded under Part A. *Aquavella* v *Richardson*, 437 F 2d 397 (2nd Cir, 1971); *Maddox* v *Richardson*, 464 F 2d 617 (6th Cir, 1972); *Davis* v *Richardson*, 460 F 2d 772 (3rd Cir, 1972); *Rothman* v *Hospital Service of Southern California*, 510 F 2d 956 (9th Cir, 1975); *American Nursing Centers, Inc., et al* v *Weinberger, et al*, 387 F Supp 1116 (S.D. Ill. 1975); *South Boston General Hospital* v *Weinberger*, 397 F Supp (W.D. Vir., 1975). Giving this judicial finding of jurisdiction, the 1972 amendments cannot be accurately depicted as curing a jurisdictional defect in the Act. Congress, by way of the 1972 amendments was not affording review where it had not existed previously. Consequently, there cannot be inferred to Congress an intent to confer jurisdiction under one subpart (Part A) and deny jurisdiction in another subpart (Part B). Such an analysis fails in its first premise

since an historical look at the judicial interpretation prior to 1972 indicates that review was not foreclosed under the Act as originally drafted.[9]

One major contention of petitioner is that the legislative history of the Medicare Act indicates that *all* review of Part B cases (except Program eligibility) is to be foreclosed. A careful reading of the history cited by the Petitioner falls short of constituting clear and convincing evidence that Congress intended to foreclose regulatory, statutory or constitutional challenges to Part B program administration.

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[9] The history of review afforded under Part A after this Court's decision in *Weinberger* v *Salfi*, 422 U.S. 749 (1975), is also noteworthy. After the *Salfi* decision was rendered, the circuits took divergent approaches to whether judicial review was available for those Part A cases arising before the effective date of the 1972 amendments to the Medicare Act. The Court of Claims found jurisdiction as to questions of law and constitutional claims. *Whitecliff, Inc.* v *U.S.*, 536 F 2d 347 (Ct. Cl., 1976) *cert den* 430 U.S. 969 (1977). The Second, Fifth and Seventh Circuits concluded that § 405(h) was a bar to federal court jurisdiction, but then, interestingly transferred the cases under consideration to the Court of Claims so that the statutory and/or constitutional challengers would have a forum. See *South Windsor Convalescent Home, Inc.* v *Mathews*, 541 F 2d 910 (2nd Cir, 1976); *Dr. John T. MacDonald Foundation, Inc.* v *Califano*, 571 F 2d 328 (5th Cir, en banc, 1978) *cert den* 439 U.S. 893 (1978); *Trinity Memorial Hospital of Cudahy, Inc.* v *Associated Hospital Service, Inc.*, 570 F 2d 660 (7th Cir. 1977). The Sixth Circuit found judicial review available. *Chelsea Community Hospital* v *Michigan Blue Cross Association*, 630 F 2d 1131 (6th Cir, 1980). The Eighth Circuit found that 405(h) was a bar to certain claims, but could not bar constitutional challenges to the Act, or its administration. *St. Louis University* v *Blue Cross Hospital Service*, 537 F 2d 283 (8th Cir 1978) *cert den* 429 U.S. 977 (1976). The importance of reciting these cases is the fact that no circuit interpreted § 405(h) and the *Salfi* opinion in such a way as to deprive the parties before them of a federal, judicial forum for constitutional claims. As indicated, even those circuits which found § 405(h) a bar transferred the case under consideration to the Court of Claims. This history of Part A cases demonstrates the extreme position petitioner is advocating. Petitioner's position would foreclose *both* Part A (for cases arising under the Medicare Act and before the effective date of the 1972 amendments) and Part B cases raising constitutional issues. Such an extreme position was rejected by the circuits deciding Part A cases and should be similarly rejected by this Court.

As to the legislative history accompanying the original 1965 Act, the cited passage indicates that "this Bill does not provide for judicial review over determinations concerning the *amount of benefits* under Part B where claims will probably be for substantially smaller amounts than under Part A." S. Rep. No. 404, 89th Cong., 1st Sess. (1965) p 55. (Emphasis added)

Similarly, the passage quoted by petitioner concerning the 1972 Amendments states:

> The situations in which Medicare decisions are appealable to the courts were intended in the original law to be greatly restricted in order to avoid overloading the courts with quite minor matters. The law refers to "entitlement" as being an issue subject to court review and the word was intended to mean eligibility to any benefits of Medicare but not to decisions on a claim for *payment for a given service*. (118 Cong. Rec. 33992, 1972). (Emphasis added)

The Conference Committee stated:

> There is no authority for an appeal to the Secretary or for judicial review on matters solely involving *amount of benefits* under Part B. H.R. Conf. Rep. No. 92-1605, 92nd Cong. 2nd Session, p 61 (1972). (Emphasis added)

Clearly, in each of the three pieces of legislative history cited by petitioner, reference is made to foreclosing review of a carrier determination concerning "payment for a given service," i.e., "amount of benefits." Amicus Curiae believes the Court of Claims was correct in the case at bar when it reviewed this legislative history and concluded that:

> These statements do not constitute "clear and convincing" evidence . . . that Congress intended to bar judicial review of constitutional and statutory challenges to benefit determinations under Part B of Medicare. The fair import of these statements is that

> Congress intended to bar judicial review of the amount of particular benefit determination—as, for example, a carrier's determination that $50 rather than the $100 a physician charged was a reasonable amount for the services.

The Court of Claims' interpretation of the operative legislative history is supported not only by the language used by Congress in discussing the Medicare Act, as emphasized in the above passages, but also by the Medicare statutes and regulations.

Section 1395ff is a clear indication that Congress did afford different review rights to different sorts of challenges. As the previous analysis of § 1395ff indicates, a challenge to one's *eligibility to participate* in Part B is accorded a review by the Secretary, § 1395ff(b)(1)(B). This section further provides for review by the Secretary for Part A challenge based upon "amount of benefits." It will be recalled that this section is silent as to review concerning "amount of benefits" under Part B. Petitioner contrasts the of review for Part B amount-of-benefit challenges. It is Amicus Curiae's position that if the absence of review for Part B amount-of-benefit challenges is to be indicative of Congressional intent to foreclose review, it certainly can be extended no further than to foreclose this very sort of challenge.

The regulations concerning the hearing conducted by the carrier are also noteworthy on this point since the regulations delineate the types of challenges to be heard by the carrier. 42 C.F.R. 405.801 provides:

> (a) Section 1842(b)(3)(C) of the Act provides that a carrier shall establish and maintain procedures under which an individual enrolled in the supplemental medical insurance plan . . . is provided with the opportunity for a hearing by the carrier when the amount in controversy is $100 or more as determined in accordance with § 405.802(b) *and he is*

> *dissatisfied with the carrier's determination denying a request for payment, or with the amount of payment under the supplementary medical insurance plan or when he believes that the request for payment is not being acted upon with reasonable promptness.* (Emphasis added)

The fair hearing conducted by the carrier, as specified by § 1395u(b)(3), is controlled by regulations promulagated by the Secretary and by certain provisions of the "Carriers Manual."[10] See 42 C.F.R. 405.802—42 C.F.R. 405.872. After an "initial determination" (42 C.F.R. 405.807), a beneficiary or provider of services is given a right to a "fair hearing" (42 C.F.R. 405.820) conducted by a hearing officer designated by the carrier (42 C.F.R. 405.823). Pursuant to regulation (42 C.F.R. 405.824), the fact that the hearing officer is an employee of the carrier "may not serve as prima facia cause for disqualification." But see *McClure* v *Harris*, 503 F Supp 409 (C.D. Cal., 1980). The hearing officer is to preside over the hearing. Evidence may be received but need not be of a sort admissible in a court of law, 42 C.F.R. 405.830(b).

The jurisdiction of the hearing officer is carefully circumscribed by regulation:

> The hearing officer is exercising the authority to conduct a hearing under § 1842(b)(3)(C) of the Act is to comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as with policy statements, instructions and other guides issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the carriers. 42 C.F.R. 405.860.

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[10] The Carriers Manual is compiled by the Health Care Financing Administration. It's declared purpose is to serve as "the practical operating instructions needed by the contractors responsible for administration of the Supplementary Medical Insurance Program—Part B Medicare." (Forward to Carriers Manual).

The restrictions imposed upon the hearing officer's jurisdiction are made even more explicit by the Carriers Manual, a compilation of guidelines the hearing officer is required by the above regulation to follow. Section 12016 of the manual states:

> Authority—The HO occupies a significant position in the administrative appeals process affording dissatisfied individuals hearing rights as provided in § 1842(b)(3)(C) of the Act. Authority of the HO is limited to the extent that he must comply with all provisions of Title XVIII of the Act and regulations issued thereunder, as well as with HCFA rulings, general instructions and other guides issued by HCFA or the Medicare Bureau. *The HO does not have the prerogative of overruling the provisions of the law or of interpreting them in a way different than that of the Medicare Bureau when he is in disagreement with their intent; nor may he use hearing decisions as a vehicle for commenting upon the legality, constitutional or otherwise, of any provision of the Act or regulations relevant to the Medicare program.* (Emphasis added)

Even if one assumes that the Medicare statute's silence (when coupled with the legislative history and regulations cited) did intend to foreclose judicial review of Part B claims which challenge payment for a given service, petitioner paints with too broad of brush and would foreclose those claims not within the authority of the hearing officer to decide, i.e., regulatory, statutory or constitutional challenges to carrier determinations. Amicus Curiae respectfully submits that, at the most, the only challenges arguably foreclosed are those which the hearing officer had authority to act upon. Clearly, petitioner has failed to show by clear and convincing evidence an intent to foreclose challenges based upon a violation of a regulation, statute or constitutional right.

To this end, the Medicare Act, regulations promulgated by the Secretary, guidelines issued by the Health Care Financing Administration, and the legislative history are all consistent with one another. The Act provides for a "fair hearing" by the carrier as to claims which challenge the amount of payment for a given service (1395u). The Act is silent concerning judicial review for *this sort of challenge* (1395ff). Legislative history indicates that an "amount-of-benefits-for-a-given-service" challenge would most likely involve a multitude of small claims which could threaten to over-tax the limited resources of federal courts. The Secretary, and its constituent agency, the Health Care Financing Administration, in performing its delegated task of operating the Program and providing guidelines to carriers who administer the Program, interpreted the statute and history and formulated a hearing process to hear this sort of challenge, i.e., a challenge to the amount of benefit for a given service. In formulating the guidelines for this hearing process, the Secretary carefully limited the sorts of challenges which could be heard by the carrier's hearing officer and specifically *excluded* legal challenges based upon a violation of regulation, statute, or constitutional right. (See 42 C.F.R. 405.801 and Carriers Manual, as previously cited).

Simple logic dictates that the words "amount of benefits" be given a consistent reading. The regulations and Carriers Manual make clear that the Secretary has interpreted §1395u(b)(3)(C) and the language "amount of benefits" so as to preclude consideration of regulatory, statutory or constitutional claims from administrative process. Petitioner should not now be allowed to read the legislative history which seeks to foreclose judicial review over "amount of benefit" cases as to give these words a different meaning and foreclose regulatory, statutory and constitutional claims since these claims, pursuant to the Secretary's own interpretation, are not "amount of benefit" claims and cannot be administratively addressed by the carrier.

The distinction between what is and what is not an "amount of benefits" challenge has been clarified by the regulations and HCFA guidelines cited previously. It is a general rule of continuing validity that this Court defers to an administrative agency's interpretation of statutes they are delegated to execute. *Udall* v *Tallman*, 380 U.S. 1 (1965); *Batterton* v *Francis*, 432 U.S. 416 (1977); *Schweiker* v *Gray Panthers*, *supra*, a N 1. Experience teaches that the normal case to appear before a carrier hearing officer is one which challenges a decision of nonpayment for a given service or one which claims that the amount reimbursed was incorrect. Under the Act, reimbursement may be denied because the service was unnecessary or unreasonable for diagnosis or treatment, § 1395y(a)(1). Additionally, the precise amount reimbursed for a particular service is calculated through a complex formulae which considers the "prevailing charge," "customary charge," "actual charge," and "80th percentile of actual charge." See § 1395u(b)(3)(E). A challenge based upon these provisions of the Act would question certain medical determinations or arithmatic calculations. These stand in contrast to other claims which pose legal challenges to the Secretary's interpretation of the law or challenge the constitutionality of the law.[11]

Pursuant to the Program guidelines, the hearing officer at a Part B "fair hearing" is a "trier of fact." (Medicare Carriers Manual, § 12020). The hearing examiner need not be an attorney (Medicare Carriers Manual, § 12016 B). The three hearing officers for the carrier in Michigan, for example, are Marcia Lennox, Thomas Ruloff, and their supervisor, Clarence Bornheim. None of these individuals are attorneys. Both Mr. Ruloff and Ms. Lennox have previously been employees of carriers in Michigan involving the administration of the program. While clearly

[11] Examples of cases which have posed legal challenges (as opposed to factual "amount-of-benefit" challenges) are cited, *infra*.

experienced in "amount of benefit" controversies, a *legal* challenge is beyond the hearing officer's jurisdiction if not competency.

The case at bar clearly involves a legal and constitutional challenge to the carrier's determination. Respondent alleged that the carrier determined the benefits illegally, i.e., not in conformity with the applicable statutory and regulatory authority and additionally alleged certain constitutional violations. Since the determination of these challenges was beyond the carrier's authority, respondent is not foreclosed from seeking a federal court forum. In sum, there is no clear and convincing evidence that Congress intended respondent's regulatory, statutory or constitutional challenges foreclosed.

An attempt to buttress petitioner's argument is made by relying upon certain provisions incorporated into the Medicare Act pursuant to § 1395(ii). This section merely provides that:

> The provision of §§ 406 and 416(J) of this Title, and of subsections (a), (d), (e), (f), (h), (i), (k), and (l) of § 405 of this Title shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter.

Section 405(h) of the Social Security Act provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under § 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

Section 405(g) of the Social Security Act provides:

> Any individual, after any final decision of the Secretary made after a hearing to which he was a part, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Secretary may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia.

It is petitioner's position that since § 405(h) was incorporated into the Medicare Act by § 1395ii and § 405(g) was not, Congress clearly intended to foreclose judicial review for all claims made under Part B.

The Medicare Act itself, §§ 1395ff and 1395oo, provides judicial review in certain instances. Petitioner's argument is, consequently, strung together with the following chain of inferences: Since 1395ii incorporated 405(h), but not 405(g), and since neither §§ 1395ff nor 1395oo explicitly provide for judicial review under Part B, Congress must have intended to foreclose review.

Whether or not § 405(h) is applied in a strict literal fashion or, as is dictated by § 1395ii, "to the same extent to which it is applicable to Title II of the Social Security Act," petitioner's reliance upon the incorporation of 405(h) is misplaced.

If a literal application is attempted, 405(h) bars judicial review of "the findings and decision of the Secretary after a hearing." Under Part B there is no hearing by the Secretary for the sort of claims made by respondent. Consequently, under a strict, literal interpretation, 405(h) is not applicable

to the Medicare Act. It is no rebuttal to content that the above interpretation would make §1395ii nugatory. Under Part A a hearing by the Secretary is conducted. Likewise, eligibility to participate in Part B is a claim reviewable by the Secretary. Therefore, § 405(h) would have application to the Medicare Act even if interpreted as above. Since respondent's claim is neither under Part A nor a question of eligibility to participate under Part B, a hearing by the Secretary is not conducted and § 405(h) preclusion of review is not applicable.

Secondly, § 405(h) precludes actions brought against the "United States, the Secretary, or any officer or employee thereof." A carrier under contract with the Secretary is neither an officer nor employee of the federal government.[12] Any legal action against the carrier, therefore, is not precluded by the language of § 405(h).

If one looks beyond the mere language of the statute and seeks to uncover the intent behind the incorporation of 405(h) into the Medicare Act, an identical result follows.

First, it should be noted that § 1395ii incorporated § 405(h) "only to the extent that [it is] applicable with respect to the 'Social Security Act." Section 405(h) does not apply to the Social Security Act so as to preclude all judicial review. Rather, § 405(g) provides for judicial review after the normal channels of administrative review have been exhausted. This was extensively discussed by this Court in *Weinberger* v *Salfi*, 422 US 749 (1975). This Court discussed the review provision of Title II of the Social Security Act and read § 405(h) as precluding original

[12] *Petitioner's argument has a basic inconsistency. First petitioner argues that there is a meaningful distinction to be found between those challenges which can be brought to hearing before the Secretary and those brought before the carrier. Since judicial review after a Secretary hearing is explicitly provided, the absence of a provision for review after a carrier hearing is relevant, so argues petitioner, since it indicates that judicial review was not intended. When the focus turns to the application of § 405(h), petitioner then argues that there is no distinction between a hearing by the Secretary and a hearing by the carrier.*

jurisdiction in Federal District Court pursuant to 28 USC§1331. However, this Court concluded that § 405(h) precluded original jurisdiction under 28 USC § 1331 since "the Social Security Act itself provides jurisdiction for constitutional challenges to its provisions." *Weinberger* v *Salfi, supra,* 422 US at 762. Petitioner's interpretation would apply § 405(h) in a manner foreign to its application in cases arising under the Social Security Act. Under petitioner's interpretation, § 405(h), while not foreclosing all judicial review under the Social Security Act, would be foreclosing judicial review under Title II, would be foreclosing judicial review of important regulatory, statutory and constitutional claims under the Medicare Act.

Secondly, the terms of § 405(h) preclude review of determinations made by the "Secretary." As previously indicated, respondent (or any other Part B provider) is not given a hearing by the Secretary, but rather by the carrier: the private insurance entity delegated the responsibility of administering the Medicare Program.[13] The difference between a hearing by the carrier and a hearing by the Secretary has been previously discussed. The jurisdiction of the Secretary when conducting a hearing under Title II of the Social Security Act is not limited to determining only the correct benefit amount. Accordingly, the provisions of 405(h) which foreclose review under Title II cannot also foreclose review under Title XVIII since review is to be foreclosed pursuant to § 1395ii only "as applied" to Title II.

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[13] Petitioner contends it would be unreasonable to interpret these statutes so as to afford judicial review from a carrier hearing, thus exposing the government to liability due to carrier error. (Pet Br, p 26). However, petitioner's argument is answered by merely referring to another section of petitioner's brief which recognizes the carrier's special expertise (because of their private insurance business) to determine reasonable change and administer Part B (Pet Br, p 22). Amicus Curiae also questions the logic by which petitioner contends that commission of errors by the carrier is reason for foreclosing judicial review. If a carrier makes a regulatory, statutory or constitutional error in administering a program involving federal funds then those errors should be rectified. Certainly, the Secretary can't argue that those errors should not be corrected merely because it has delegated the decision-making process to a private entity.

B. IF CLEAR AND CONVINCING EVIDENCE TO FORECLOSE ALL REVIEW FOR ALL PART B CLAIMS IS ESTABLSIHED THE MEDICARE STATUTE (42 USC § 1395ff) WOULD BE AN UNCONSTITUTIONAL DENIAL OF DUE PROCESS.

Petitioner's Brief is a creative attempt at statutory construction but sadly relegates the U.S. Constitution to footnote status (see Pet Br, nts, 13, 39). It is Amicus Curiae's position that the principle of due process is keenly intertwined with the issue presented in the case at bar.

The inquiry into Congressional power to restrict the jurisdiction of the inferior federal courts has a long history with this Court. *Ex Parte McCardle*, 7 Wall. 506, 19 L. Ed. 264 (U.S., 1869); *United States* v *Klein*, 13 Wall. 128 (U.S. 1872). While commentators have taken different views concerning the extent of Congressional power in the area,[14] the fact remains that the foreclosure of jurisdiction to hear constitutional claims has been looked at with ascance by this Court. *Crowell* v *Benson*, 285 U.S. 22 (1932), *St. Joseph Stock Yards Co.* v *United States*, 298 U.S. 38, (1936).

It is only elementary to appreciate that constitutional principles play upon a case such as this on two levels. The first level concerns jurisdiction and unquestionably involves careful statutory construction but also includes the principle of due process. It is an inquiry into whether a court is empowered to even consider a case. The second level concerns the substantive merits of a claim when those merits are based upon constitutional rights. Petitioner's Brief suggests this Court need not be concerned with either level of constitutional analysis since the lower court found the substantive merits of respondent's constitutional claim

[14] Jaffe, *Judicial Control of Administrative Action*, 376-94 (1965); K. Davis, *Administrative Law in the Seventies*, § 2809 (1976); P. Bator, P. Miskin, D. Shapiro and H. Wechstler, *The Federal Courts and the Federal System, Note on Power of Congress to Limit the Jurisdiction of Federal Courts*, 313-375 (2d Ed. 1973).

lacking. Petitioner would seemingly ignore the whole first level of analysis. The Court of Claims concluded that it had jurisdiction and then went on to discuss the substantive merits of respondent's constitutional claims. The fact that the Court of Claims found those claims to be without merit does not mean that the presence of respondent's constitutional claims need not be considered. It is only after jurisdiction is accepted that substance is considered. The gravamen of the present case concerns not the merits of respondent's constitutional claims, but rather, respondent's ability to find a forum in which to assert those constitutional claims. This, however, is a consideration which brings the Constitution into play on the first level.

It is Amicus Curiae's position that any construction of the pertinent statutes which precludes judicial review of regulatory, statutory or constitutional challenges to the administration of the Medicare Act would be to invalidate the relevant provisions of the Act as constituting an unconstitutional denial of due process.

In *Johnson* v *Robison*, 415 U.S. 361 (1974), this Court was engaged in a task similar to the one currently undertaken. A statute made certain administrative determinations final and conclusive. However, when faced with a claimant who made substantive constitutional claims, this Court refused to give the statute its literal effect since to do so would have denied claimant a forum to voice constitutional challenges. The Court stated:

> Plainly, no explicit provision of § 211(a) bars judicial consideration of appellee's constitutional claims. That section provides that "the decision of the Administrator on any question of law or fact under any law administered by the Veterans Administration providing benefits for veterans . . . shall be final and conclusive and no . . . court of the United States shall have power or jurisdiction to review any such decision . . ." The

> prohibitions would appear to be aimed at review only of those decisions of law or fact that arise in the *administration* by the Veterans Administration of a statute providing benefits for veterans. A decision of law or fact "under" a statute is made by the Administrator in the interpretation or application of a particular provision of the statute to a particular set of facts, Appellee's constitutional challenge is not to any such decision of the *Administrator*, but rather to a decision of *Congress* to create a statutory class entitled to benefits that does not include I-O conscientious objectors who performed alternative civilian service. Thus, as the District Court stated: "The questions of law presented in these proceedings arise under the Constitution, not under the statute whose validity is challenged." (Emphasis in original) *Johnson* v *Robison, supra*, at 367.

Accordingly, this Court refused to apply the disputed statute so as to preclude judicial review of constitutional claims since "[s]uch a construction would, of course, raise serious constitutional questions concerning the constitutionality of [the disputed statute]." *Johnson* v *Robison*, supra, at 366.

Petitioner relies upon this Court's more recent decision in *Weinberger* v *Salfi, supra*, wherein this Court specifically considered the effect § 405(h) has upon judicial review. In *Weinberger* v *Salfi, supra*, a widow applied for Social Security insurance benefits for her daughter by a previous marriage. Her application was denied since her second husband died before her daughter could qualify as the child of her second husband. The Court held that jurisdiction pursuant to 28 U.S.C. § 1331 was barred by the third sentence of § 405(h). However, the *Salfi* decision does not lead to the conclusion that § 405(h) bars jurisdiction in the case at bar pursuant to 28 U.S.C. 1491. In *Salfi*, this Court carefully distinguished the earlier opinion in *Johnson* v *Robison*, by noting:

> [Robison] was expressly based, at least in part on the fact that if [the provision challenged in Robison] reached constitutional challenges to statutory limitations, then absolutely no judicial consideration of the issue would be available. Not only would such a restriction have been extraordinary, such that "clear and convincing" evidence would be required before we would ascribe such intent to Congress, 415 U.S. at 373, 94 S.Ct., at 1168, but it would have raised a serious constitutional question of the validity of the statute as so construed. *Id*, at 366-367, 94 S.Ct., at 1165. In the present case, the Social Security Act itself provides jurisdiction for constitutional challenges to its provisions. Thus the plain words of the third sentence of § 405(h) do not preclude constitutional challenges. They simply require that they be brought under jurisdictional grants contained in the Act, and thus in conformity with the same standards which are applicable to non-constitutional claims arising under the Act. 422 U.S. at 762.

The result in *Salfi* was reached in main part because the rule expressed in *Johnson* (Congressional foreclosure of all forums in which to bring substantive constitutional claims would raise serious constitutional questions) was not violated. This Court observed that the Social Security Act did provide a forum and that the claimant was simply guilty of not making his challenges in the correct forum. In essence, this Court approved of a "jurisdictional detour" in *Salfi*—not a "jurisdictional bar."

The statutory scheme here, if interpreted as suggested by petitioner, would deny Part B providers and beneficiaries a forum to address not only constitutional challenges but regulatory and statutory challenges as well. As previously demonstrated, the carrier is specifically not empowered to address these challenges.

The present case is not a matter of whether a hearing at a meaningful time and meaningful manner is conducted. See *Armstrong* v *Manzo*, 380 U.S. 545 (1965). Rather, it is of a more rudimentary nature and concerns whether any hearing at all will be provided to regulatory, statutory or constitutional challenges addressed to the administration of a major social program—Medicare. Amicus Curiae suggest that due process mandates such a hearing and forum.

In assessing due process claims, this Court has employed a flexible scale which balances the importance of the rights at stake against the procedural rights afforded. The factors to consider were delineated by this Court in *Mathews* v *Eldridge*, 424 U.S. 319, 335 (1976):

> [O]ur prior decisions indicate that identification of the specific dictates of due process generally requires consideration of three distinct factors: First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

The application of this test to the case at bar shows that the foreclosure of all judicial review would clearly deprive respondent of their due process rights. As an assignee of Medicare benefits, respondent has an interest protected by the Due Process Clause of the Fifth and Fourteenth Amendments.[15] This Court has on previous occasions

[15] An assignee's interest in Medicare benefits is equivalent to a beneficiary's interest. See § 1395(b)(3)(B)(ii); 42 C.F.R. 405.801; *Szekely* v *Florida Medical Association*, 517 F 2d 345 (1975) *cert den* 425 U.S. 980 (1976).

"implicitly recognized" a like interest in the receipt of Social Security benefits.[16] *Richardson* v *Belcher*, 404 U.S. 78 (1971); *Richardson* v *Perales*, 402 U.S. 389 (1971); *Flemming* v *Nestor*, 363 U.S. 603 (1960).

Secondly, the risk of an erroneous deprivation of respondent's rights is exceedingly high. Where no forum to address basic regulatory, statutory or constitutional challenges is provided, grave violations can easily occur. This can be poignantly demonstrated by assuming certain factual circumstances. The Part B carrier has been delegated wholesale administration of the Medicare Program and the hearing officer is charged with applying the Secretary's guidelines to the letter. However, if no review from the carrier "fair hearing" is provided, even the Secretary's own guidelines could go unheeded. Such unbridled authority could be used arbitrarily and capriciously, either for or against the government's interest. [Indeed, there may very well be carrier determination the Secretary wishes to appeal. See *Aquavella* v *Harvey*, 615 F 2d 12 (2nd Cir 1979)]. Numerous hypothetical situations can be postulated.

If the Secretary decided to no longer reimburse for treatment of sickle cell anemia or to reimburse foreign trained physicians at a lower rate than domestically trained physicians, these flagrant violations of equal protection rights under the Fourteenth Amendment would be denied expression, in any forum. Or, if the carrier decided not to comply with the applicable regulations and refused to accord a provider or beneficiary a "fair hearing," how would that beneficiary or provider challenge this basic denial of due process?

While these facts are hypothetical, a survey of litigation which has arisen indicates that legal challenges to the administration of the Program have been made and that federal courts have found several of the challenges to be meritorious and demonstrative of violations to the U.S. Constitution.

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[16] *Mathews* v *Eldridge*, supra, at 332.

In *McClure* v *Harris*, 503 F Supp 409 (C.D. Cal., 1980), Part B beneficiaries claimed that the "fair hearing" procedures under Part B violated their rights to due process and equal protection of the law and unconstitutionally delegated judicial power to private entities. The District Court concluded that appointment of the hearing officer by the carrier was violative of due process since the hearing officer would have prior involvement in the case (since a carrier employee) and a pecuniary interest (since their incomes as hearing officers were dependent upon whether the carrier enlisted their services). The Court further concluded that the delegation of authority to the carrier's hearing officer likewise offended the requirements of due process of law.

In *Michigan Academy of Family Physicians, et al* v *Blue Cross and Blue Shield of Michigan, et al*, 502 F Supp 751, (E.D. Mich., 1980), the carrier had established certain reimbursement "screens" which entailed the separation of allopathic physicians and placement of family physicians into a "screen" including podiatrists and chiropractors for purposes of determining reasonable charges under Part B of the Medicare Program. The District Court found that this action violated the patient's choice of physician as guaranteed by the Medicare statute, §1395a, and violated §1395u(v)(3), which provides for the setting of reasonable charges according to the customary charges of physicians for similar services. Although the District Court found that because the actions of defendant violated the Medicare statute it need not consider the constitutional arguments raised by plaintiffs, the Court characterized the actions of the carrier as discriminatory, not rationally related to any legitimate purpose of the Medicare statute and defying all reason.

In *St. Jude Manor Nursing Home, Inc.* v *Richardson*, No. 72-681 (M.D. Flor., filed July 27, 1974) reported in CCH, Medicare and Medicaid Guide at New Developments, ¶ 27, 226, a Federal District Court was faced with a

regulation promulgated by the Secretary that provided that neither the insurance carrier nor the Secretary could be made a party to the administrative hearing. The beneficiary and/or provider was the *only* party required to appear. The District found the regulation violative of "minimum standards of due process" since the insurance carrier or Secretary would not be bound by any administrative order if not a party.

While these three cases demonstrate both constitutional and statutory challenges, their importance is not so much that the claimant's merits were found persuasive as the fact that a forum existed in which to make these claims. The interpretation of the previously cited statutes urged by petitioner would foreclose a judicial forum for these types of cases.

Lastly, there would be no great fiscal or administrative burden imposed by requiring that some forum for regulatory, statutory, and constitutional challenges be found. In *McClure* v *Harris, supra,* at 416, the Court considered the government's interest and stated:

> The government clearly has a strong interest in controlling the costs associated with the Part B Medicare program. However, it is far from clear that the imposition of Part A hearing procedures would entail substantial additional costs. As defendants point out, more than 124 million Part B claims were processed by carriers in 1978. Only a fraction of those claimants pursue their currently available appeal remedies (i.e., review determinations and hearings). If an appeal to the Secretary is made available, there is no indication that anything but an even smaller group of claimants will actually pursue this additional remedy. Moreover, the cost of providing such additional remedy will be minimized by the fact that the Secretary already maintains an appeal procedure, utilizing administrative law judges, for Part A claimants. To enable Part B claimants to

> appeal adverse hearing officers' decisions to Part A administrative law judges would not require the creation of a new appeals system or a new bureaucracy. It would simply increase the number of claimants who utilize the existing Part A administrative appeal. That would not be a cost-free change from the status quo, but neither should it be a costly one.

Additionally, the process of assignment also works so as to limit the total number of appeals which would be brought. As explained earlier, assignment serves to group claims and results in challenge that more typically go beyond questioning the amount to benefits for a given service.

In short, Amicus Curiae believes that to interpret the Medicare Act to foreclose judicial review for all claims made under Part B would be tantamount to making § 1395ff of the Act unconstitutional. A longstanding principle of statutory construction is to interpret statutes so as to avoid possible constitutional infractions. *United States* v *Thirty-Seven Photographs*, 402 U.S. 363 (1971); *Johnson* v *Robinson, supra*. The availability of a meaningful forum in which to bring legal challenges is a hallmark of our notion of due process. In Justice Frankfurter's words, "The right to be heard before being condemned to suffer grievous loss of any kind . . . is a principle basic to our society." *Joint Anti-Fascist Committee* v *McGrath*, 341 U.S. 123, 168 (1951) (Frankfurter, J., concurring).

III. SUMMARY OF ARGUMENT

In order for petitioner to prevail in the within case, it must be shown by clear and convincing evidence that 42 U.S.C. §§ 1395ff and 1395ii show a legislative intent to deprive beneficiaries and providers under Part B of Medicare a forum in which to raise regulatory, statutory or constitutional challenges to the administration of the Medicare Program. Section 1395ff neither expressly grants nor expressly denies review from these sorts of challenges. Despite petitioner's best effort, Congressional silence cannot be transposed into a clear and convincing showing of Congressional intent.

The legislative history cited by petitioner is also unconvincing since that history shows no more than an intent to foreclose review of beneficiaries or providers who challenge the "amount of benefits for a given service." The Secretary of Health, Education and Welfare has interpreted § 1395ff, and its history, so as to draw a distinction between "amount of benefits" challenges on the one hand, and regulatory, statutory or constitutional challenges on the other. Under the petitioner's interpretation of § 1395ff and its history, a beneficiary or provider of services under Part B of Medicare would not only be denied an administrative forum to make regulatory, statutory or constitutional challenge, but would be denied a judicial forum as well.

Furthermore, the incorporation of § 405(h) of Title II of the Social Security Act [42 U.S.C. § 405(h)] by § 1395ii does not show clear and convincing Congressional intent to foreclose review of all Part B cases. Section 405(h) forecloses judicial review after an administrative hearing conducted by the Secretary. An administrative hearing under Part B is conducted by a hearing officer appointed by the insurance carrier who has been delegated the responsibility for the administration of Medicare-Part B.

Additionally, this Court's interpretation of § 405(h) in *Weinberger* v *Salfi*, 422 U.S. 749 (1975) does not lead to the foreclosure of review in the within case. Pursuant to §

1395ii, § 405(h) is only to be applied to the Medicare Act to the extent to which it is applicable to Title II of the Social Security Act. In *Salfi*, this Court interpreted 405(h) as foreclosing 28 U.S.C. 1331 judicial review of constitutional claims since those claims could be made in the administrative hearing provided coupled with an alternative source of judicial review. Since no such administrative forum to address constitutional claims exists under Part B of Medicare, § 405(h) should not be incorporated into the Medicare Act in such a way as to foreclose judicial review.

Secondly, if it is assumed, arguendo, that petitioner has shown Congressional intent to foreclose review, any such Congressional intent would constitute a denial of due process of law under the Fifth Amendment to the Constitution. Since the administrative hearing afforded to Part B claimants cannot address constitutional challenges to Program administration, the denial of any forum in which to address these challenges is a denial of due process of law. In balancing the rights being violated against the governments interest, it is clear that serious legal challenges to the Medicare program cannot go without a forum for expression without violating the due process rights granted by the Constitution.

CONCLUSION

For the reasons indicated, Amicus Curiae requests that this Court affirm the decision of the Court of Claims.